



CALIFORNIA STATE ATHLETIC COMMISSION

Offices: 1424 HOWE AVENUE, SUITE 33, SACRAMENTO, CA 95825-3217 (916) 263-2195 FAX (916) 263-2197
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REPORT OF PHYSICAL EXAMINATION R E F E R E E

NAME	DATE OF BIRTH / /		
ADDRESS (street)	(city)	(state)	(zip code)

HISTORY: Has applicant ever had any of the following:

- ☐ Swollen Joints ☐ Rheumatism ☐ Frequent Headaches ☐ Chronic Cough ☐ Spitting of Blood
☐ Shortness of Breath ☐ Convulsions (fits) ☐ Fainting Spells ☐ Blurring of Vision ☐ Rupture (hernia)
☐ Chest Pain ☐ Operations _____ Ever been a patient in a mental hospital? ☐ Yes ☐ No
 Other hospitalizations? ☐ Yes ☐ No If yes, explain fully _____

EYE EXAMINATION:

Vision without glasses: Right _____ / _____ Left _____ / _____
(Must have uncorrected visual acuity of at least 20/100 in both eyes pursuant to Athletic Commission Rule 371)

GENERAL EXAMINATION:

General appearance _____ Height _____ Weight _____
(Is weight proportionate to height in accordance with standards of the AMA? Pursuant to Rule 371) ☐ Yes ☐ No

Temperature _____ Disabling scars _____ Mouth _____ Teeth _____ Tonsils _____ Neck _____
 Pulse at rest _____ Blood pressure at rest _____
 Pulse after 100 hops _____ Blood pressure after 100 hops _____
 Blood pressure 2 minutes later _____

Enlarged glands: ☐ Yes ☐ No Goiter: ☐ Yes ☐ No
 Heart: Pulse rhythm ☐ Regular ☐ Irregular Apical impulse ☐ Heavy ☐ Normal
 Lungs: Rales ☐ Yes ☐ No
 Abdomen: Enlargement of liver ☐ Yes ☐ No Enlargement of spleen ☐ Yes ☐ No
 Hernia – Femoral _____ Inguinal _____ Ventral _____

Unhealed wounds: _____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____
 Skin: Rash _____ Boils _____ Any other _____

REMARKS: _____

I have examined the above named subject and I ☐ DO FIND ☐ DO NOT FIND this person to be physically and mentally fit and in good physical condition with the speed and reflexes necessary for the protection of boxers. Nor did I find a condition that would preclude him/her from being licensed as a referee.

 LICENSED PHYSICIAN'S NAME AND LICENSE NUMBER (please print)

 PHYSICIAN'S SIGNATURE

 STREET ADDRESS

 DATE

 CITY STATE ZIP CODE

 PHONE NUMBER

I declare under penalty of perjury under the laws of the State of California, that the foregoing information is true and correct; further, I realize that any intentional misrepresentation may result in disciplinary action against my license.

 SIGNATURE OF APPLICANT

(Please Complete Other Side)

AUTHORIZATION FOR RELEASE
(R e f e r e e)

I AUTHORIZE the State Athletic Commission under subdivision (b) of Section 1798.24 of the Civil Code to RELEASE any medical information or other personal information with respect to my status and licensure as a referee which may be contained in any of its records. The commission agrees to release this information only to those Athletic Commissions of other jurisdictions, or professional boxing associations which have a need to know the information requested as determined by the commission.

I AGREE that a photographic copy of this authorization shall be valid as the original.

I AGREE that this Authorization will be valid until it expires one year after the expiration of my license on the 31st of December of this year unless I apply for a license and sign another Authorization.

DATE

SIGNATURE OF REFEREE

LOCATION

NAME PRINTED